CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

MEETING MINUTES

MEDI-CAL CHILDREN'S HEALTH ADVISORY PANEL (MCHAP)

Date:	Thursday, September 11, 2025
Time:	10 a.m. – 2 p.m.
Type of Meeting:	Hybrid
Members Present:	15
Public Attendees:	101
DHCS Staff Presenters:	Michelle Baass, Director; Laura Miller, MD, Medical Consultant, Quality and Population Health Management; Pamela Riley, MD, MPH, Assistant Deputy Director and Chief Health Equity Officer, Quality and Population Health Management; Lori Bradley, Division Chief, Pharmacy Benefits Division
Additional Information:	Please refer to the PowerPoint presentation used during the meeting for additional context and details.

Member Attendance:

- Michael Weiss, M.D.; Present; In Person
- Ellen Beck, M.D.; Present; Virtual
- Elizabeth Stanley Salazar; Present; Virtual
- Diana Vega; Present; Virtual
- Nancy Netherland; Present; In Person
- Jeff Ribordy, MD, MPH, FAAP; Present; Virtual
- Karen Lauterbach; Present; In person
- Kenneth Hempstead, M.D.; Present; In person
- William Arroyo, M.D.; Present; Virtual
- Ron DiLuigi; Present; Virtual
- Lesley Latham, D.D.S., MS; Present; In person

- Alison Beier; Present; Virtual
- Jovan Salama Jacobs, Ed.D; Present; Virtual
- Kelly Motadel, M.D.; Present; In-Person
- Jan A. Schumann; Present; Virtual

10:00 – 10:10	Welcome, Opening Comments, Roll Call, and Agenda
10:10 – 10:50	Director's Update
10:50 – 11:35	California Population Health Management Service: Medi-Cal Connect
11:35 – 12:35	Improving Preventive Care Outcomes in Early Childhood
12:35 – 1:05	Break
1:05 – 1:35	Medi-Cal Rx
1:35 – 1:45	Public Comment
1:45 – 2:00	Final Comments and Adjourn

Welcome and Introductions

Type of Action: Action

Recommendation: Review and approve the March 13, 2025, meeting minutes.

- **Presenter:** Dr. Michael Weiss, Chair, welcomed meeting participants and read the legislative charge for the advisory panel.

Materials/Attachments: MCHAP Meeting Minutes - March 13, 2025

Action: Approve the minutes from November 7, 2024

- **Aye:** 10 (Weiss, Hempstead, Netherland, Lauterbach, Motadel, Schumann, Beck, Vega, Beier, Ribordy)
- **Didn't Vote:** 4 (Arroyo, DiLuigi, Latham, Jacobs)
- **Members Absent:** 0
- **Abstentions:** 1 (Salazar)

Motion Outcome: Passed

Director's Update

Type of Action: Information

Presenter: Michelle Baass, Director

Discussion Topics:

- The Director's Update included information on MCHAP governance, outlining Chairperson responsibilities, term limits, and the process for the 2026 election. Draft bylaws were introduced to consolidate existing statutory requirements from SB 220 and Bagley-Keene. The update also summarized key provisions of the enacted H.R.1 reconciliation legislation and its projected impacts on Medi-Cal, including mandatory work requirements, six-month eligibility redeterminations, and reduced retroactive coverage—changes that could result in coverage losses for up to 3.4 million members. Additional provisions include new cost-sharing requirements, restrictions on provider taxes and State Directed Payments (SDP), and limitations on immigrant coverage. The update also noted a temporary ban on federal Medicaid funding for certain abortion providers and introduced the Rural Health Transformation Fund as a mitigation strategy for impacted rural health systems.
- A member asked if there is a difference in how the bylaws are applied to stakeholder groups that are not established in statute. DHCS clarified that advisory bodies created in statute are required to follow the Bagley-Keene Open Meeting Act. In contrast, groups formed outside of statute, such as ad hoc workgroups or policy-based advisory committees, are not legally bound by Bagley-Keene, though DHCS generally follows its principles as a best practice. The primary distinction lies in whether the group is established through statute.
- A member asked if the adoption of bylaws for the panel would require a 90-day public comment period or review by the Office of Administrative Law (OAL). DHCS responded that such requirements typically apply to formal regulations, which this panel does not develop or adopt. Therefore, the administrative rulemaking process, including a 90-day comment period, does not apply. DHCS emphasized that the bylaws do not introduce new practices but instead formalize existing procedures to promote transparency and consistency across departmental advisory bodies.
- A member asked if the state will continue collecting the Managed Care Organization (MCO) Tax while awaiting a decision from the federal government on whether California's existing MCO Tax structure complies with the new

requirements under H.R.1, including restrictions on provider taxes and potential transition periods. DHCS responded that the state is currently working with federal partners to clarify the status of the tax and related waiver. The member then asked if 49 other states are in the same situation. DHCS clarified that while 49 other states use provider taxes, the structure and design of these taxes vary. As a result, not all states are affected in the same way as California. In a follow-up question, the member asked if any collective legal action has been taken by states. DHCS responded that California has not entered into litigation and is awaiting further federal guidance, including on how broad-based and uniform requirements will be applied. DHCS also noted that a draft federal rule was released recently, and California submitted comments. Additional guidance is pending.

- A member acknowledged the challenges facing DHCS and expressed concern about the impact of H.R.1 on vulnerable populations, particularly undocumented individuals and those losing eligibility due to immigration status changes. The member asked if there are plans to proactively support Medi-Cal members in meeting new work requirements through education or volunteer opportunities, and if partnerships could be developed to expand access to such pathways. The member also inquired about any plans to restore services for individuals affected by the reclassification of immigration status. DHCS responded that an outreach plan is required under H.R.1 and is currently in development. DHCS is coordinating with workforce, education, and volunteer agencies to identify ways members can meet work requirements. Regarding immigration status, DHCS stated that approximately 200,000 members will shift to unsatisfactory immigration status (UIS) as of October 1, 2026, and that implementation planning is ongoing.
- A member asked if the MCO Tax still allows the state to draw down federal funds and raised a concern about how Medi-Cal's race and ethnicity data collection may affect American Indian and Alaska Native members' exemption from work requirements. Specifically, the member noted that multi-ethnic individuals may not be properly identified and could be subject to requirements from which they should be exempt. DHCS responded that while provider taxes are still allowed under H.R.1, California's current MCO Tax structure does not meet the new federal requirements due to differences in how commercial and Medi-Cal plans are taxed. As a result, the value of the tax is expected to decrease significantly.

DHCS also acknowledged the concern about data classification and said it would be taken into consideration during outreach and implementation planning.

- A member asked if automation would apply to both re-enrollment and work requirement exemptions, and emphasized the need for accessible appeal processes if automation results in coverage loss. The member also raised concerns about difficulty reaching county offices and asked for clarification on changes to retroactive coverage. DHCS confirmed that automation efforts are primarily focused on identifying mandatory exemptions from work requirements to reduce administrative burden and prevent unnecessary disenrollment. DHCS acknowledged the concern about appeals and noted it as an important consideration. Regarding retroactive coverage, DHCS explained that under H.R.1, coverage for expansion adults will be limited to one month prior to application, and to two months for other Medi-Cal applicants, replacing the current three-month standard.
- A member raised concerns about the financial impact of H.R.1 provisions on California's children's hospitals, particularly safety net and freestanding facilities, and asked if DHCS plans to engage with hospital associations to assess and address these impacts. DHCS acknowledged the concern and stated that the state does not have the fiscal capacity to replace the anticipated loss of federal funding. DHCS noted that changes to SDPs will require significant redesign and that discussions with stakeholders, including children's hospitals, will be part of that process. DHCS emphasized the importance of aligning with CMS expectations around quality outcomes as part of future SDP planning.
- A member expressed concern about delays in Medi-Cal re-enrollment and eligibility verification, noting that families are already experiencing wait times of 45 to 90 days. They shared an example of a family who moved out of state after waiting 90 days without coverage, unable to access needed care for their child. The member emphasized that existing infrastructure may be unable to handle the increased demands under H.R.1 and called for creative solutions and additional support for families navigating the system. They also raised concerns about the limited effectiveness of the current grievance process and suggested the need for a more responsive feedback mechanism to identify and address issues before they escalate. The member encouraged collaboration to build infrastructure that supports families and ensures timely access to benefits.
- A member asked how much flexibility states will have in verifying work requirements for non-exempt populations, noting the potential administrative

burden for both individuals and the state. DHCS responded that under H.R.1, CMS is not required to issue implementation guidance until June 2026, so the extent of state flexibility remains unclear, and it is uncertain how CMS will enforce compliance. DHCS also referenced related provisions in H.R.1 that eliminate federal waivers for good faith errors in eligibility determinations, emphasizing the need to meet federal standards with integrity despite limited clarity at this stage.

- A member expressed appreciation for DHCS' efforts in presenting complex information clearly and acknowledged the challenges DHCS is facing. They emphasized the group's willingness to offer support, guidance, and subject matter expertise, and expressed optimism about continued collaboration to ensure children's needs are met.

California Population Health Management Service: Medi-Cal Connect

Type of Action: Information

Presenter: Laura Miller, MD, Medical Consultant, Quality and Population Health Management

Discussion Topics:

- The presentation on California's Population Health Management Service introduced Medi-Cal Connect, a data-driven platform designed to support whole-person care and improve health outcomes for Medi-Cal members. The service aims to integrate data from multiple sources to inform care delivery, policy, and population health strategies. Key goals include reducing disparities, enhancing cross-sector collaboration, and enabling proactive, personalized care. The rollout is occurring in six phases through 2026, gradually expanding access to DHCS, managed care plans (MCP), county partners, and Tribal organizations. Features highlighted include the Longitudinal Member Record (LMR), quality measure dashboards, and tools to support care management, particularly for children's health. The platform also supports risk stratification, program eligibility tracking, and demographic-based quality analysis to inform targeted interventions.
- A member asked about HIPAA compliance and whether medical directors from one Medi-Cal MCP can access member-level data from another MCP. DHCS explained that access to the LMR is role-based and managed by each plan's

administrator. Staff at MCPs, including medical directors and other authorized personnel, may be granted access if their role supports care coordination or utilization management. When a member transitions to a new MCP, their historical data from the previous plan becomes available to the new MCP through Medi-Cal Connect. State agencies have more limited access, with additional safeguards in place. The member also asked how Medi-Cal Connect aligns with the Data Exchange Framework (DXF). DHCS responded that DXF serves as the statewide roadmap for data exchange, while Medi-Cal Connect is a tool operating within that framework. DHCS noted that data acquisition remains a challenge, but DXF is expected to support future improvements.

- A member asked if vision data is included in Medi-Cal Connect and if users can access detailed electronic health record (EHR) content, such as physician notes or after-visit summaries. DHCS confirmed that vision data had previously been missing and acknowledged the importance of including it. DHCS also clarified that Medi-Cal Connect is not an EHR system; it provides a limited set of data, primarily from claims, with a 3–6 month lag, and does not include clinical notes or real-time updates. The member raised concerns about data accuracy and the lack of a member-facing portal to review or correct information. DHCS acknowledged the issue, noting that while a member portal was originally planned, it was not implemented due to funding limitations and concerns about duplicating existing systems. Currently, members cannot view or dispute their data within Medi-Cal Connect. The member emphasized the importance of user access to ensure data accuracy and reduce disparities, especially when providers rely on this information for care decisions. DHCS confirmed that all data access is logged for accountability and agreed that coordination of care and identifying high utilizers are key benefits of the system. The member also cautioned against the potential for unconscious bias if providers rely too heavily on flagged data without context.
- A member asked how Medi-Cal Connect will support outcome measurement, particularly for chronic and behavioral health conditions; whether the system could inform improvements to the behavioral health carve-out model; and how unmet needs and service gaps will be reported. DHCS responded that Medi-Cal Connect includes more than 140 quality measures and allows DHCS staff to access and analyze data more efficiently, supporting real-time insights into outcomes. Regarding behavioral health, DHCS noted that the system will integrate medical and behavioral health claims, enabling better coordination

when members transition between systems. Behavioral health plans are expected to be onboarded in late 2025. While Medi-Cal Connect will not determine policy changes to the carve-out model, it may help reduce silos through improved data visibility. On reporting unmet needs, DHCS clarified that Medi-Cal Connect is not a public-facing tool and does not replace existing public dashboards. However, the suggestion to generate reports on unmet needs and gaps was acknowledged as a valuable idea and may be considered for future planning.

- A member asked if Release 6 of Medi-Cal Connect would extend access to care managers at Federally Qualified Health Centers (FQHC) and similar provider organizations. DHCS confirmed that the intent is to include a broad range of partners, including community-based organizations, though access and permissions will be carefully managed. The member then asked if patients would have any indirect ability to influence the data. DHCS agreed, noting that while members do not have direct access, they may review information with their care managers and raise questions or concerns during those interactions.
- A member raised concerns about how Medi-Cal Connect will handle protected health information related to adolescent confidentiality, such as visits for sexual or reproductive health or substance use disorder (SUD) treatment, which are typically restricted from parental access in standard EHR systems. DHCS acknowledged the concern and stated that Medi-Cal Connect is based on claims data and does not currently have a mechanism to mask or segregate sensitive visit information. While access is limited to vetted users who have completed HIPAA training, DHCS agreed to take the question back for further review and clarification.

Improving Preventive Care Outcomes in Early Childhood

Type of Action: Information

Presenter: Pamela Riley, MD, MPH, Assistant Deputy Director and Chief Health Equity Officer, Quality and Population Health Management

Discussion Topics:

- The presentation on improving preventive care outcomes in early childhood emphasized children's preventive care as a key clinical focus within DHCS' Comprehensive Quality Strategy. It outlined Medi-Cal's strategy to support children and families through eight action areas, including strengthening

coverage, enhancing pediatric preventive care, and addressing behavioral health needs. The presentation highlighted accountability measures tied to well-child visits, immunizations, developmental screenings, and other key indicators, noting both progress and ongoing challenges. California's performance on early childhood preventive care remains below national benchmarks, particularly in well-child visits. The presentation shared best practices and successful interventions by MCPs, such as mobile units, practice transformation efforts, and community partnerships. It also emphasized the importance of data quality, provider and member engagement, and the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. DHCS will participate in a CMS-led affinity group beginning in late 2025 to further improve early childhood preventive care through a structured quality improvement initiative.

- A member expressed concern about children under age 18 who may lose Medi-Cal coverage in the coming years. The membe emphasized the importance of understanding what happens to these children at the community level and questioned how the state will continue to track and support them, particularly in accessing preventive services, like vaccinations. DHCS acknowledged the complexity of the issue and stated that while it may not be possible to prevent all coverage losses, efforts are underway to mitigate the impact. DHCS noted that this period presents an opportunity for innovation, including revisiting past workaround strategies and developing new solutions. Emphasis was placed on the importance of engaging community-based organizations and implementing local-level approaches to maintain access to care for children who may no longer be enrolled in Medi-Cal.
- A member responded to the earlier discussion by stating that while many children who lose Medi-Cal coverage will likely still receive care, providers will not be reimbursed, which will increase the burden on clinics, hospitals, and especially FQHCs. They noted that this impact will be uneven across the state. The member also addressed challenges with the W15 well-child visit measure, explaining that their organization often misses early visits because infants are not seen until 2 months of age. They shared that by conducting chart reviews and identifying visits that met well-visit criteria, even if not billed as such, their W15 rate increased by 25%, reaching the 75th percentile. They emphasized that the issue is primarily related to data capture, not service delivery. The member also expressed concerns about mobile and school-based clinics, particularly regarding continuity of care. As a primary care pediatrician, they noted that

children may see a provider only once, with no knowledge of their medical or medication history. They added that school-based clinics often face limitations due to insurance coverage and existing primary care relationships, which can result in fragmented care. While acknowledging that these models may increase visit rates, they questioned whether they support high-quality, continuous care. DHCS acknowledged the concerns and agreed that ensuring children receive care is the priority, especially in situations where access is limited. DHCS also emphasized the importance of linking community-based services to primary care and agreed that improving data collection and reporting is a key part of quality improvement efforts.

- A member expressed appreciation for the increased availability of data shared with the panel, noting that it reflects progress on long-standing requests for more detailed information. They emphasized the need for more opportunities for member input beyond formal channels like corrective action plans (CAP) and grievances. Drawing from personal experience as a parent of a child with complex medical needs, the member shared that billing data they obtained did not align with their actual care experience, raising concerns about how accurately metrics reflect patient realities. They encouraged DHCS to prioritize member voices in shaping and evaluating metrics, suggesting that members be asked directly what barriers they face and what questions they feel should be asked. They also highlighted the importance of engaging members in defining what wellness and health should look like from their perspective. As a final point, the member raised a separate issue regarding the need to prioritize dental varnish programs for children, referencing recent legislative interest. DHCS responded by agreeing on the importance of creating more effective feedback loops for member engagement and acknowledged the value of approaching member needs with curiosity, especially in the context of advancing health equity. DHCS noted that building trust and considering alternative measures of success are essential. DHCS also committed to following up on the question about dental varnish programs.
- A member raised a suggestion regarding the Combo 10 immunization measure, noting that it does not fully reflect access or quality due to the outsized influence of flu vaccine rates, which are often affected by vaccine hesitancy. They recommended that DHCS also report a version of the measure excluding flu to better identify bright spots and assess system performance. The member also asked how panel members could learn more about specific outreach pilots or

messaging strategies that are proving effective, especially given that some common approaches, such as correcting misinformation, can sometimes worsen hesitancy. They requested a resource or site where such best practices might be shared. DHCS agreed that the Combo 10 measure presents challenges and acknowledged the need to balance measurable indicators with meaningful insights. They shared that efforts are underway to work with the quality transformation team to compile and publicize best practices more broadly. The member encouraged collaboration with CDPH and other partners to help socialize successful strategies. DHCS confirmed that CDPH has been a strong partner and will be represented in the upcoming CMS affinity group focused on preventive care.

- A member shared that their clinic frequently receives requests for mobile care and has found that combining vaccination services with onsite enrollment support is most effective. They emphasized the importance of helping individuals understand their Medi-Cal status and connect with primary care providers, rather than disrupting continuity of care. The member also raised concerns about the recent public confusion surrounding the CDC and its impact on vaccine programs. They noted that misinformation has led to increased skepticism and challenges at the local level, including parents questioning school vaccine requirements. They asked whether California has a plan to address this ongoing issue and expressed appreciation for any official state-level guidance that could help counteract national uncertainty. DHCS acknowledged the value of the mobile clinic model when paired with enrollment and primary care linkage, and agreed that identifying best practices for these services is important. In response to the vaccine concerns, DHCS stated that it is working internally on these issues and continues to prioritize vaccine access in partnership with public health agencies. DHCS highlighted the West Coast Health Alliance as a trusted source for data and recommendations and noted that California's public health leadership, including Dr. Kwan, is actively working on clear communication strategies to support vaccine confidence.
- A member offered three suggestions related to preventive care. First, they noted that fluoride varnish is not reimbursed by Medi-Cal in primary care settings for children older than age 5, even though not all children have established dental homes by that age. They shared that some MCPs independently reimburse for varnish beyond age 5 to support care and improve performance metrics. Second, they encouraged DHCS to partner with District 9 of the American Academy of

Pediatrics (AAP) in California, citing the AAP's extensive vaccine-related resources and ongoing efforts that could support state initiatives. Third, they suggested examining the use of Z codes related to vaccine refusal in California compared to other states. While acknowledging that CMS is unlikely to adjust performance expectations based on refusal rates, they noted that such data could help distinguish between access issues and hesitancy. The member also emphasized that many families associate well-child visits primarily with vaccinations, which can influence their decision to seek care. The member later clarified that fluoride varnish is reimbursed in dental offices for children older than age 5, but not in primary care settings. DHCS responded by thanking the member and agreeing on the importance of understanding whether low vaccination rates are due to access barriers or refusal, and identifying where further analysis is needed.

- A member emphasized the importance of early childhood preventive care, especially its connection to identifying developmental needs through the education system. They raised concerns about inconsistent communication and service access across Regional Centers in California, even within the same county. They also suggested strengthening partnerships between health systems and schools, as families often view schools as trusted sources for information and support. DHCS responded that it is working with Children Now and other advocates to improve connections between primary care and early intervention services, including Regional Centers. DHCS noted ongoing efforts to strengthen referral pathways and population health management policies. DHCS also acknowledged the importance of school partnerships and said it would explore how health plans are engaging with schools to reach children who may not otherwise access care.
- A member shared a detailed reflection on the disconnect between the health care system and the families it serves. While acknowledging DHCS' progress in improving equity and transparency, they emphasized that patients and families often feel excluded from care planning and decision-making. Drawing from personal experience as a parent of children with different health care needs, they described how even highly engaged families struggle to prioritize preventive care due to emotional fatigue, logistical barriers, and system complexity. They highlighted issues, such as red tape, limited access to referral information, and the burden of navigating multiple steps for routine services, like hearing screenings. The member also stressed the importance of making preventive care

feel urgent and relevant, suggesting stronger communication strategies, such as persistent outreach from providers and clearer messaging about long-term health benefits. They raised concerns about fragmented care in mobile and school-based settings and emphasized that every health care interaction shapes trust in the system. Additional suggestions included tracking turnaround times for services and improving access to health records for adolescents and their families. DHCS thanked the member for their insights, acknowledging both the practical and systemic challenges raised. DHCS also emphasized that meaningful progress depends on listening to and partnering with the people being served, not just in program design, but in building systems that empower members as true collaborators in care.

- A member shared that the California Dental Association is co-sponsoring a bill to mandate Medi-Cal and commercial insurance coverage for fluoride varnish treatments in primary care settings for children under age 2.

Medi-Cal Rx

Type of Action: Information

Presenter: Lori Bradley, Division Chief, Pharmacy Benefits Division

Discussion Topics:

- The Medi-Cal Rx presentation provided updates on pediatric pharmacy claims and prior authorization (PA) activity following implementation. As of June 2025, approximately 78% of pediatric claims were paid without a PA, while 22% required one, primarily due to the drug prescribed. The presentation also outlined budget-related changes, including the implementation of step therapy and revised continuation of therapy policies, which may increase PA requirements for non-California Children's Services (CCS) Panel Providers. Updates included efforts to improve access and reduce administrative burden through system enhancements, expanded coverage, and provider education. Additional topics included proposed support for youth aging out of CCS, such as a one-time 100-day override to prevent care disruptions, and improved communication around the emergency fill policy to address access issues.
- A member shared a personal account of the challenges their family faced following the Medi-Cal Rx transition in January. Their daughter, a CCS enrollee with complex medical needs, experienced a disruption in access to a critical

medication that significantly improved her health. Due to the provider not being paneled with CCS and an aid code suppression issue, the prescription was suddenly limited, and the family was not notified of the denial. This led to a decline in the child's condition and a return to hospital-based care. The member described extensive efforts to resolve the issue, including contacting multiple departments across DHCS, Medi-Cal Rx, UCSF, and their MCP. They noted that appeals submitted by the provider were not recognized due to a technical issue with how they were labeled. Although the medication was eventually restored, the member emphasized the emotional and logistical toll of navigating the system and the need for better emergency fill processes, clearer communication, and inclusion of families in system transitions. They also highlighted the broader concern that families should not need to rely on personal networks or high-level escalation to resolve access issues.

- A member shared a positive experience with the Medi-Cal Rx PA process, noting that a recent prescription for an adolescent was approved quickly and easily. They then raised concerns about access barriers in rural areas, particularly within the Partnership HealthPlan of California service area, where many children are seen by mid-level providers or family practitioners who may not be CCS-paneled. They emphasized that refills for existing prescriptions should not be delayed due to provider paneling status. The member also pointed out that residents at tertiary care facilities often prescribe medications, but are not CCS-paneled, which can create additional access issues. They encouraged DHCS to consider ways to reduce these barriers.
- A member asked for clarification on the Medi-Cal Rx PA process, confirming that PA is only required for medications not listed on the Contract Drug List (CDL) or Covered Products List. DHCS confirmed this and noted that providers can check PA requirements through the Medi-Cal Rx website and provider manual. The member then suggested that DHCS consider allowing certain medications, such as those for blood pressure or immunosuppression, to bypass PA requirements based on diagnosis or medication category. They shared a personal example where their son needed a blood pressure medication, but faced a delay due to PA, emphasizing that such delays can be risky and burdensome for patients and families.
- A member suggested that DHCS consider allowing PA exemptions based on diagnosis or clinical scenarios, especially for medications that are critical and time-sensitive. They shared an example of a pediatric patient who could have

received Epogen during an infusion visit but was delayed due to PA requirements, resulting in a more painful administration later. They emphasized that certain medication categories, such as blood pressure or immunosuppressive drugs, should be prioritized for immediate access to avoid unnecessary hospitalizations. DHCS responded that some medications may require PA due to cost or quantity limits, but noted that CCS-paneled providers can bypass some of these requirements. DHCS also clarified that PAs are reviewed within 24 hours and that emergency fills are available to prevent care delays. DHCS confirmed that patients can receive two 14-day emergency fills within a 30-day period.

- A member raised broader concerns about delays in care caused by prior authorization processes, sharing an example of a leukemia patient who was hospitalized after multiple prescription denials. They encouraged DHCS and the pharmacy program to examine the impact of such delays on health outcomes. The member also supported the proposed 100-day medication bridge for foster youth and suggested expanding it to other populations at risk of losing Medi-Cal coverage. Additionally, they proposed launching multilingual outreach campaigns, such as radio ads, to encourage enrollment before coverage changes take effect, particularly for undocumented individuals. DHCS responded that the 100-day bridge concept is under internal review and acknowledged the importance of broader outreach. Another member supported the idea of proactive communication, especially through social media or other channels, to help families maintain coverage and access to care.

Public Comment

Type of Action: Public Comment

Discussion Topics:

- **Isha Nayak**, an undergraduate student at Cal Poly San Luis Obispo and member of the California Children's Vision Now Coalition, shares that she is working on a grant focused on improving children's access to vision care. She stated that she has attempted to obtain vision-related claims data from DHCS, but was unable to locate relevant datasets on the public dashboard. Nayak explains that she submitted data requests through the DHCS portal, which have been marked as completed, but she has not yet received the requested files. She adds that follow-up messages through the portal and phone calls to the data research

committee have gone unanswered. Nayak asked whether there is a way to expedite the data request process, emphasizing that the data is critical for her team's analysis and efforts to improve children's vision care.

- **Kristine Schultz,** Executive Director of the California Optometric Association, thanked DHCS for the presentation on Medi-Cal Connect and echoed concerns raised earlier about the absence of vision care in the data set. She noted that while primary care, dental, and mental health were mentioned, vision was not. Schultz emphasized that including vision data is important, particularly in cases where a child is brought in for behavioral concerns, highlighting that some children diagnosed with ADHD may simply need an eye exam. She also pointed out the importance of tracking whether diabetic patients have received their annual eye exams to help prevent blindness. Schultz adds that if vision data is included through Medi-Cal claims, that is encouraging, but she urges DHCS to ensure that vision is clearly represented in the main dashboard and not buried in less visible sections.
- **Doug Major, OD**, representing California Children's Vision Now, shared that he has begun his 40th year conducting school vision screenings. He emphasized the significant need for vision care, referencing a recent demonstration screening at San Arroyo School attended by leadership, including Speaker Rivas and their team. Of the 80 children screened, 40 were found to need eye exams, many with farsightedness that affects reading speed. Major stressed the importance of making vision care data accessible, especially for members of the Quality Improvement and Health Equity Committee. He expressed concern that the data feels hidden or not transparent and urged DHCS to share claims data with managed care plans. He believes that access to this data will lead to improvements in care delivery and emphasized that the data already exists. He highlights the potential for teams, including those at Cal Poly, to use tools like artificial intelligence to analyze the data and drive change. Major expressed discomfort that programs like Medi-Cal Connect have demonstrated transformative results in other counties, while vision care data remains difficult to access. He urged DHCS to provide MCPs with children's vision care data to help improve California's national ranking, currently 51st. He closed by giving an invitation to attend future screenings, emphasizing that while screenings are valuable, they are ineffective without follow-up access to care.
- **Theresa Andrews,** representing GeneDX, shared that her organization believes everyone deserves personalized, targeted medical care, beginning with a genetic

diagnosis. She first thanked DHCS for providing clear direction in implementing SB 496 related to biomarker testing. Andrews then addressed EPSDT, noting that in June, the American Academy of Pediatrics issued updated guidance recommending exome and genome sequencing as first-tier tests for children with global developmental delay or intellectual disability. She explains that this recommendation is based on the superior diagnostic yield and greater cost-effectiveness of these tests when conducted early in the diagnostic process. Although this testing should qualify under EPSDT, Andrews stated that most California children currently do not have access to it because the relevant codes are not yet included in the Medi-Cal fee schedule. She shared that GeneDX is in the process of submitting a Medi-Cal benefit request form and looks forward to working with DHCS to make this a covered benefit for children in California. *A written public comment was also submitted by Theresa and can be accessed here.*

Member Updates

Type of Action: Information

Discussion Topics:

- A member emphasized the importance of making it easy for patients to access care, warning that turning someone away may result in them not returning. They cautioned against a one-size-fits-all approach, particularly in the context of PAs and prescription limits, and suggested that policies should account for high-risk patients. They reiterated the need to reduce barriers and simplify access to care.
- A member expressed appreciation for the meeting and acknowledged the difficulty of presenting updates related to federal mandates, particularly those tied to the H.R.1 legislation. They described the situation as a significant setback and emphasized the importance of resolving issues related to the MCO Tax and provider taxes, which have historically helped California draw down federal Medicaid matching funds. The member encouraged DHCS to continue working with federal partners and consider litigation, if necessary. They also supported California's collaboration with Washington and Oregon as part of a regional policy effort and urged continued evaluation of the viability of provider-based funding mechanisms.
- A member reiterated three key suggestions. First, they encouraged DHCS to examine the impact of upcoming coverage losses on populations, such as

undocumented individuals, refugees, and asylees, and to develop plans to mitigate those effects. Second, they recommended gathering data on the impact of delays in care, whether due to limited access to medications or specialty services, at a statewide level. Third, they supported outreach efforts like radio or social media campaigns to encourage enrollment before coverage changes take effect. The member closed by expressing appreciation for the work of both DHCS staff and fellow panel members.

Upcoming MCHAP Meeting and Next Steps

Type of Action: Information

Presenter: Mike Weiss, M.D., Chair

Discussion Topics:

- The next meeting is scheduled for November 6, 2025.
- MCHAP will continue to be a hybrid meeting until further notice.

Adjournment of Meeting

Name of person who adjourned the meeting: Michael Weiss, M.D.

Time Adjourned: 2 p.m.